REASSESSMENT INFORMATION - ADOPTION ASSISTANCE PROGRAM

CHILD'S NAME
CHILD'S DATE OF BIRTH
CHILD'S AAP BENEFIT CASE NUMBER
COUNTY

DUE DATE (14 DAYS AFTER DATE MAILED)

The purpose of this form is to provide the adoption agency with an update of the needs of the child for whom you are receiving an Adoption Assistance Program (AAP) benefit and Medi-Cal coverage. Failure to complete and return this form within two weeks (14) days of the date it was mailed may cause interruption or delay in your receipt of the benefit. If this form is not returned to the adoption agency by the date it is due, the agency will conclude that an AAP benefit is no longer required and the AAP benefit and Medi-Cal coverage may stop. **Please complete, sign and date this form within two weeks,** attaching extra sheets if necessary, and send it to:

NAME OF ADOPTION AGENCY
ADDRESS
TELEPHONE ( )

Check (✓) one of the following:

☐ We are legally responsible for the support of the child, and we are supporting the child.

☐ We are no longer legally responsible for the support of the child.

☐ We are no longer supporting the child.

Check (✔) one of the following

☐ 1. I/We no longer wish to receive an AAP benefit and/or Medi-Cal coverage for the above-named child. If the child's need change, I/we may contact the agency at that time.

☐ 2. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. The needs of the child have not changed to warrant a reduced level of payment, nor has there been any change in the child's income. I/We request that the AAP benefit continue at the current level. I/We understand that my/our child's next reassessment date will be on _____.
NEXT REASSESSMENT DATE

☐ 3. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I am/we are requesting an increase in the AAP benefit because the needs of the child have changed. I am/we are providing the agency the following information to assist the agency in determining whether or not increased assistance will be granted, and if so, in what amount. **(Please complete Section I.)**

☐ 4. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I/We request that the AAP benefit for the above named child be decreased to $_____because the needs of the child have changed. I/We understand if at anytime the child's needs change we may contact the agency to renegotiate the AAP benefit.

SECTION I

1. I am/We are requesting an increased AAP benefit based on the following needs of the child and circumstances of the family:

_____

_____

_____

_____

_____

_____

☐ I have attached written documentation to assist the adoption agency in making its determination.

2. CHILD'S INCOME

a. This Child's Monthly Unearned Income

Social Security . . . . . $_____ (MONTHLY)

SSI/SSP . . . . . $_____ (MONTHLY)

Other . . . . . $_____ (MONTHLY)

Child's Total Income: . . . . . $_____ (MONTHLY) X 12 = $ 0.00 (ANNUAL)

3. HEALTH INSURANCE

Does the family have Health Insurance . . . . . ☐ YES ☐ NO

If YES, name of Insurance Plan: _____

Is the child currently covered by this Insurance? . . . . . ☐ YES ☐ NO

If NO, reason:_____

4. OTHER INFORMATION

a. Is the child a Regional Center client? . . . . . ☐ YES ☐ NO

If YES, which Regional Center: _____

5. MONTHLY AMOUNT OF AAP BENEFIT CURRENTLY RECEIVED, IF ANY

For Basic Care *(Food, Clothing, Shelter, etc.)* . . . . . $ _____

For Meeting Special Needs . . . . . $ _____

I/We certify through my/our signature(s) that the information provided in this Reassessment Information - Adoption Assistance Program form is true and correct to the best of my/our knowledge and belief. I/We make this statement under the penalty of perjury and understand that any willful concealment or misstatement of material fact in this request for adoption assistance may subject me/us to the penalties prescribed for perjury in the California Penal Code.

_____ _____ _____ _____

SIGNATURE OF ADOPTIVE PARENT | Date | SIGNATURE OF ADOPTIVE PARENT | Date

FAMILY ADDRESS

TELEPHONE

( )